



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4812 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

HOUSTON ORTHO SURG HOSPITAL LLC  
5420 WEST LOOP SOUTH #3600  
BELLAIRE TX 77401

DWC Claim #:  
Injured Employee:  
Date of Injury:  
Employer Name:  
Insurance Carrier #:

#### **Respondent Name**

FACILITY INSURANCE CORP

#### **Carrier's Austin Representative Box**

Box Number 19

#### **MFDR Tracking Number**

M4-12-3064-01

#### **MFDR Date Received**

JUNE 5, 2012

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary as stated on the Table of Disputed Services:** "Denied for timely filing. Proof is certified [sic] card signature from an employee of International [sic] Solutions C. Perry 7/27/2011. "

**Amount in Dispute:** \$184.60

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "This is a medical fee dispute concerning service date July 19, 2012. Carrier did not receive the original bill on these services until December 31, 2011. This was not within 95 days of the service date. Accordingly, reimbursement was denied. Requestor has subsequently asserted that it sent its bill on March 23, 2012. Carrier review of the billing records shows, however, that the certified mailing on that date submitted only a July 18, 2012 service date and not the services currently in dispute. Carrier maintains its position that no reimbursement is owed for these services."

**Response Submitted by:** Flahive, Ogden & Latson, PO Drawer 201329, Austin, TX 78720

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 19, 2011	Outpatient Hospital Services	\$184.60	\$0.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.

3. 28 Texas Administrative Code §102.4 sets out the rules for non-Commission communications.
4. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
5. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 29 – The time limit for filing
  - 863-101 – The time limit for filing has expired. The statute of limitations has expired.
  - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
  - 901 – Reconsideration no additional payment. Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

### **Issues**

1. What is the timely filing deadline applicable to the medical bills for the services in dispute?
2. Did the requestor forfeit the right to reimbursement for the services in dispute?

### **Findings**

1. 28 Texas Administrative Code §133.20(b) states, in pertinent part, that, except as provided in Texas Labor Code §408.0272, “a health care provider shall not submit a medical bill later than the 95<sup>th</sup> day after the date the services are provided.” The requestor submitted a copy of a USPS green card that shows a bill was submitted to the insurance carrier and received by the carrier on July 27, 2011; however, the respondent submitted a medical bill for date of service July 17, 2011 that reflects a received date of July 27, 2011 and also has the certified mail number copied onto the bill. The bill submitted by the carrier does not reflect the same date of service or same services. No documentation was found to support that any of the exceptions described in Texas Labor Code §408.0272 apply to the services in this dispute. For that reason, the requestor in this dispute was required to submit the medical bill not later than 95 days after the date the disputed services were provided.
2. Texas Labor Code §408.027(a) states, in pertinent part, that “Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment.” 28 Texas Administrative Code §102.4(h) states that “Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday.” Review of the submitted information finds no documentation to support that a medical bill was submitted within 95 days from the date the services were provided. Therefore, pursuant to Texas Labor Code §408.027(a), the requestor in this medical fee dispute has forfeited the right to reimbursement due to untimely submission of the medical bill for the services in dispute.

### **Conclusion**

For the reasons stated above, the division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

### **ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

### **Authorized Signature**

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Signature	Medical Fee Dispute Resolution Officer	July 25, 2012 Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**